



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

JAN 12 2022

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to House Report 116-442, page 150, accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021, on Behavioral Health Requirements of the Department of Defense (DoD), is enclosed.

The report provides an assessment of the number of behavioral health providers needed to treat beneficiaries in the Military Health System; the cost to recruit and retain providers; a strategy to increase the use of tele-behavioral health; a plan to inculcate behavioral health treatment as a form of overall Service member readiness; and a strategy to increase the number of behavioral health providers, including standardized credentialing requirements. The report outlines the methodology to calculate the number of providers needed to care for the beneficiary population and the associated costs to recruit and retain these providers. Increasing the number of behavioral health providers is a priority for DoD.

Thank you for your continued strong support for our Service members, civilian workforce, and families. I am sending a similar letter to the Committee on Armed Services of the Senate.

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", written in a cursive style.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member



PERSONNEL AND
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UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

JAN 12 2022

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

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Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

Report to Congress



Behavioral Health Requirements of the Department of Defense

**Requested by: House Report 116-442, Page 150, Accompanying
H.R. 6395, the William M. (Mac) Thornberry National Defense
Authorization Act for Fiscal Year 2021**

The estimated cost of this report or study for the Department of Defense (DoD) is approximately \$31,100 for the 2021 Fiscal Year. This includes \$5,100 in expenses and \$26,000 in DoD labor.

EXECUTIVE SUMMARY

This report addresses the behavioral health (BH) provider shortages in the Department of Defense (DoD) as requested by House Report 116-442, page 150, accompanying H.R. 6395, the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021. Key elements include: an assessment of the number of BH providers needed to treat beneficiaries of the Military Health System (MHS); the cost to recruit and retain these providers; a strategy to increase the use of tele-BH and recommendations for needed legislation; a plan to inculcate BH treatment as a form of overall Active Duty Service member (ADSM) readiness; and a strategy to increase the number of BH providers, including standardized credentialing requirements.

INTRODUCTION

A nationwide shortage of BH providers is reflected in the DoD and impacts the Department's ability to provide BH care for beneficiaries. This, in turn, negatively impacts military readiness. Increasing the number of BH providers is a priority for the Department, but is a complex problem that must be addressed with various strategies.

NUMBER AND TYPES OF MILITARY, CIVILIAN, DIRECT CONTRACT, AND CIVILIAN NETWORK BEHAVIORAL HEALTH PROFESSIONALS REQUIRED TO TREAT MEMBERS OF THE ARMED FORCES AND COVERED BENEFICIARIES

Direct Care:

A standard methodology based on certain assumptions was used to determine the number and types of BH professionals required to treat ADSMs and covered beneficiaries. In order to define demand, BH services utilization data for FY 2019 was consolidated. This pre-coronavirus disease 2019 (COVID-19) data was utilized as it was determined to be more representative of "normal" demand, although it is recognized that demand has likely increased based on DoD efforts at destigmatizing and normalizing BH care. For military readiness reasons, it was assumed all ADSMs would be treated in direct care. Finally, as ADSMs generally tend to be healthier than the general population, we additionally assumed 25 percent of non-active duty beneficiaries would be treated in direct care, which contributes to clinical skills maintenance supporting provider military readiness.

As BH departments provide both treatment and non-treatment services, an encounter based model was applied to determine demand for each military medical treatment facility (MTF). Individuals accessing BH services were assumed to be "patients" if they had more than three visits. Individuals with fewer than three visits were assumed to have accessed BH services for non-treatment reasons (e.g., clearances, one time evaluations), and those encounters were counted as only one encounter. Patients in psychotherapy, typically with non-prescribing providers such as psychologists and social workers, had an expected episode of care requirement of once a week for eight weeks. Patients in treatment with prescribers, such as psychiatrists and

psychiatric mental health nurse practitioners, had an expected episode of care of once every 24 days for six sessions per patient.

Each MTF was assessed independently. The need-based model was applied to calculated demand to determine the required number of therapists and prescribers. Provider need basis, by provider type, was then validated by each Military Department, and each Military Department also incorporated any additional requirements incurred as a result of mission-related changes or information that could not be assessed at a macro level. In addition, the Military Departments provided data regarding staff needed for their BH inpatient units, graduate and student training programs, and other special programs. Results are displayed in Table 1.

TABLE 1: PROPOSED PROVIDER TOTALS BY TYPE AND SERVICE

Service	Provider Type Totals	Active Duty	Civilian	Contractors	Total
Air Force	Therapist Totals	409	505	-	914
Air Force	Prescriber Totals	109	6	22	137
Army	Therapist Totals	167	1,719	31	1,917
Army	Prescriber Totals	150	163	25	338
Navy	Therapist Totals	551	83	55	689
Navy	Prescriber Totals	150	22	15	187
	All Totals	1,536	2,498	148	4,182

**NOTE: THESE NUMBERS REFLECT ONLY BH PROVIDERS EXCLUSIVELY TO DELIVER BH CARE IN THE MTF CLINICS*

Excluded from these numbers are the BH providers in the following categories/ missions outside of MTF BH care: Family Advocacy Program, substance abuse counselors, deployed BH providers, Service Readiness mission, non-clinical staff positions (i.e., Region and Headquarters), prevention/outreach, Primary Care BH, Integrated Disability Evaluation System, and Unit BH providers (i.e., embedded, fleet). The Military Departments estimate a requirement for an additional 2,000 providers to fill these non MTF Specialty BH roles and services. This brings the total BH providers required to approximately 6,182.

Per section 720 of the NDAA for FY 2020, the DoD is authorized 5,132 BH providers (FY 2019 data) with approximately 4,957 on board. This results in a gap of approximately 1,050 BH provider authorizations/billets to meet the BH demand of delivering care in the clinics as well as the other related missions related to Readiness and outlined in the paragraph above. Lastly, this does not include additional para-professional and administrative staff required to maintain provider productivity in outpatient and inpatient settings. Other costs such as facility and infrastructure costs and information technology (IT) support are also not included.

Civilian Network:

The TRICARE managed care support contractors (MCSCs) are required to maintain a network of civilian providers sufficient to meet non-MTF BH care demand for TRICARE beneficiaries within required access standards. Each MCSC uses a proprietary formula to determine the number of each category of BH providers they need in the network to support the BH needs of the TRICARE beneficiaries in their respective geographic region. Access to civilian BH providers is dependent on many factors such as location, type of BH provider required, number

of BH providers in the area, and the willingness of BH providers to participate in TRICARE. This, in turn, impacts the number of providers required.

The adequacy of each MCSC’s network is assessed by TRICARE on a monthly and annual basis using referral, claims, and access to care data. Performance is determined using several measures such as claims paid to network versus non-network providers, referrals to non-network providers due to network deficiency, and the MCSC’s ability to meet TRICARE access to care standards. Despite the change the COVID-19 pandemic had on health care operations across the nation, the method of measuring network adequacy and the compliance with contract requirements has not changed and overall performance has been satisfactory.

SPECIFIC INFORMATION ON THE AMOUNT OF FUNDING NEEDED TO HIRE AND RETAIN BEHAVIORAL HEALTH PROFESSIONALS TO TREAT COVERED BENEFICIARIES

Direct Care:

Civilian/Contract Prescribers: Cost was based using psychiatry given the low density of psychiatric mental health nurse practitioners (PMHNPs). Civilian psychiatrist cost basis was taken from the median for the Physicians and Dentist Pay Plan General Schedule (GS) pay scales based on the locality pay of the MTF with benefits included. The cost basis for contract psychiatrists was \$300K annually. Estimates do not include additional benefits such as moving expenses or educational loan repayment benefits that might be needed to attract personnel to hard-to-fill locations.

Civilian/Contract Therapists: Provider type was split 60/40 between social workers and psychologists reflecting the enterprise percentage distribution across the MHS. Civilian social worker cost basis was calculated using the GS-12, step 5 rate. Civilian psychologists cost basis was calculated using the GS-13, step 5 rate. Contract social workers and psychologists were both cost at \$130K annually. Estimates do not include additional benefits such as moving expenses or educational loan repayment benefits that might be needed to attract personnel to hard-to-fill locations.

TABLE 2: TOTAL ANNUAL COST BY SERVICE AND PROVIDER TYPE

Service Totals	Total Civ and Con	Active Duty	Total
Air Force Total	\$ 67,636,588	\$114,968,477	\$ 182,605,064
Army Total	\$ 272,273,153	\$ 71,530,781	\$ 343,803,933
Navy Total	\$ 28,213,722	\$147,494,899	\$ 175,708,621
Total	\$ 368,123,462	\$333,994,157	\$ 702,117,619

** NOTE THAT THIS COST IS TO HIRE AND RETAIN BH PROVIDERS EXCLUSIVELY TO DELIVER BH CARE IN THE MTF CLINICS*

Active Duty (AD) Providers: The cost generator from the Cost Assessment and Program Evaluation (CAPE) website was utilized. As retention and recruitment bonuses are important

tools for all Military Services, but not included in the CAPE website for psychologists and social workers, a 15 percent additional cost was included for these providers.

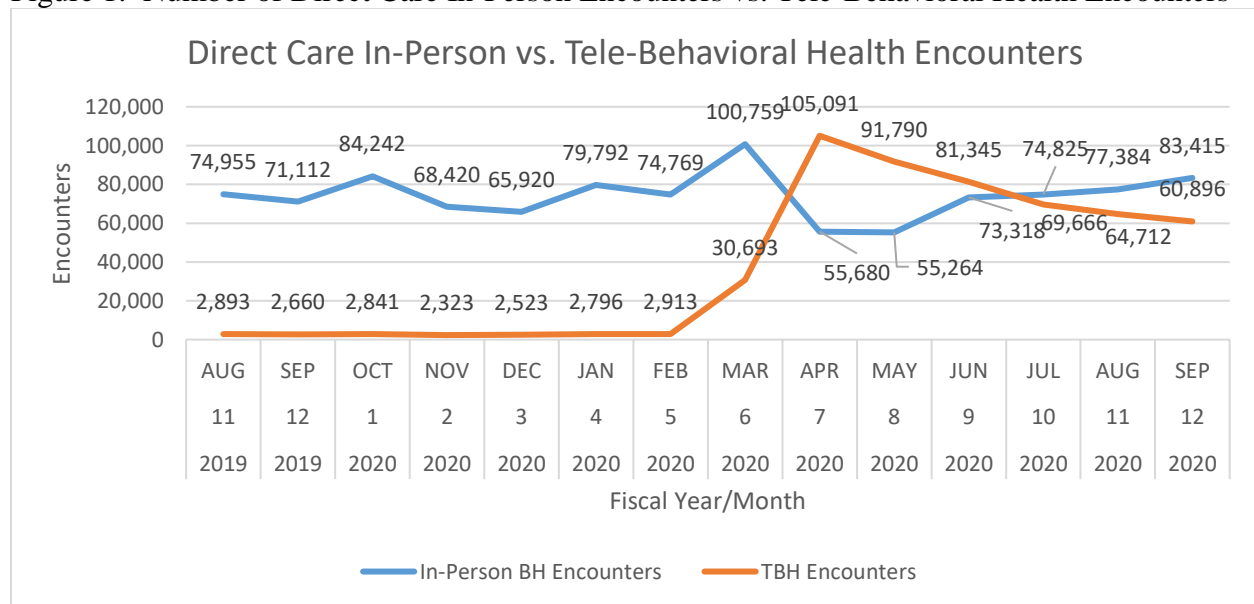
Civilian Network:

To determine funding needed to maintain a civilian network sufficient to meet the demand, we reviewed total civilian network expenditures from FY 2016 – 2019. The cost has consistently increased each year from \$800,000,000 in FY 2016 to over \$1 billion in FY 2019. Therefore, approximately \$1 billion is needed to meet demand. In the event the Department is successful in providing care for up to 25 percent of the civilian network BH care, as stated above, then this cost for private care BH services would be decreased appropriately.

A PLAN TO PROVIDE BEHAVIORAL HEALTH TREATMENT TO BENEFICIARIES USING TELEHEALTH SERVICES AND OTHER TECHNOLOGIES, INCLUDING ANY RECOMMENDATIONS OF THE SECRETARY REGARDING LEGISLATION

For the past decade, Tele-Behavioral Health (TBH) has been the most utilized Virtual Health (VH) service in both direct care and the civilian network as a way to efficiently and effectively provide BH services to remote beneficiaries. Even so, in the seven months prior to the exacerbation of COVID-19 within the United States (August 1, 2019 – February 29, 2020) the direct care providers had a monthly average of 76,880 (538,159 total) in-person BH and TBH encounters combined, with less than 5 percent of the appointments being TBH (see Figure 1).

Figure 1: Number of Direct Care In-Person Encounters vs. Tele-Behavioral Health Encounters



The number of in-person BH encounters remained stable during the past 14 months (August 1, 2019 – September 30, 2020) except for a decrease during the height of the initial response to COVID-19 (March 2020 – May 2020), while the demand for TBH appointments increased starting in March 2020. For the first five months of the COVID-19 period (March 1, 2020 –

July 31, 2020), direct care providers had a monthly average of 147,686 (738,431 total) combined BH and TBH encounters with over 50 percent of the appointments being TBH. This 92 percent increase in total BH encounters since the initial COVID-19 response demonstrates the value and capacity that TBH adds to the enterprise. However, since July 2020, TBH encounters have started to decrease with a concurrent rise in in-person encounters.

Also during COVID-19, the civilian network made rapid changes to support the use of VH, including authorizing reimbursement for VH visits and Intensive Outpatient BH treatment, waived VH visit cost shares for beneficiaries, and recognizing temporary state licensure waivers for interstate care. In addition, the TRICARE Health Plan expanded private sector care TBH options, with a focus on patients in remote and rural areas. According to TRICARE figures, the MHS spent \$1,494,746 (20,218 visits) on TBH claims during the seven months prior to the start of the COVID-19 pandemic emergency (August 1, 2019 – February 29, 2020), and \$84,466,382 (978,964 visits) during the first six months of the pandemic emergency (March 1, 2020 – September 30, 2020). This is 56-fold increase since the start of the pandemic emergency.

A synchronized strategy and plan that includes an appropriate care delivery platform, equipment resources, provider support, and training and education for both providers and patients is paramount. Technical platforms, workflows, support protocols, recruitment, and training need to be in place at an enterprise level as well as appropriate policies and legislation to solidify the support for TBH services. The MHS plan to provide TBH across the enterprise focuses on the below actionable items as the Defense Health Agency (DHA) assumes authority, direction, and control of the MTFs:

Standardized Training. DHA will develop two standardized trainings: (1) a general VH training which targets all medical disciplines; and (2) a TBH specific training. These trainings will be integrated into staff orientation to ensure all BH providers have a baseline foundation of how to deliver BH care virtually.

- The general VH training will cover a variety of topics to include how to use the virtual platform, documentation requirements, coding, and any additional virtual health requirements for effective virtual health care.
- The TBH specific training will focus on transitions from in-person care to virtual care, and how to adapt clinical practice to a virtual setting,

In addition to developing the training content, DHA will also develop tools to monitor compliance with training requirements.

Capacity and Template Management. As DHA assumes authority, direction, and control of the MTFs, the market and MTF leaders will work together with DHA to determine the approximate percentage of appointments that need to be dedicated TBH. The percentages of dedicated TBH appointments will vary from MTF to MTF in order to meet the local conditions such as demand and available civilian network capacity. The dedication of a percentage of appointments for TBH sets a contextual expectation for providers to continue to utilize TBH. “TBH Hubs” will help to provide direct care for ADSMs outside a MTF’s 40-mile catchment area and enrolled to

Tricare Prime Remote in order to ensure operational readiness and support surges or provider gaps across the enterprise. TBH will allow ADSMs to obtain the support and care they deserve regardless of their geographical location.

Equipment/IT Systems. All Direct Care Network (DCN) BH providers will be equipped with tools to provide TBH services, including computers, cameras, and headsets.

Team of Champions. DHA will build a team of TBH Champions at the enterprise and market levels to support providers, patients, and support staff with regular training, technical support, and resources which will encourage continued use of the TBH platform.

Metrics and Research. DHA will continue to gather data on TBH utilization and barriers across all TBH. This data will identify best practices, report provider and patient satisfaction (vital to sustainment), and highlight treatment outcomes.

Policies and Development of Standards of Care. TBH introduces additional risk for providers and patients. For instance, a BH patient that is in crisis and reporting suicidal or homicidal intentions may experience a delay in first responder intervention. This delay is the result of the process required to activate local emergency services from afar. The BH provider first identifies the patient's location, then must determine the emergency services closest to patient location and lastly activates the appropriate emergency service. This must be accomplished while keeping the patient on the virtual platform and engaged in crisis response planning. As a result, risk mitigation policies will be developed and implemented. This risk mitigation policy will be evidence based and consistent with the Department of Veterans Affairs (VA)/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide.

Civilian Network Future:

In order to support continued development and utilization of TBH through the civilian network, the TRICARE Operations Manual is being updated in preparation for the next generation of TRICARE contracts. These updates include requirements for TRICARE Contractors to obtain and maintain nationally recognized accrediting organization accreditation for its telehealth network and to make available to network and MTF providers for challenging cases, teleconsultation with expert specialists at institutions with nationally recognized specialty-specific accreditation in the appropriate medical field. Contractors will be required to provide a report on the ability of beneficiaries to access telehealth services in rural, remote, and isolated areas for the performance assessment of the telehealth network and will be required to maintain a network that includes secure telehealth services accessible to all TRICARE plan enrollees without Medicare Part B in the contractor's geographic area of responsibility. For TBH specifically, TOM updates include requiring the contractor to ensure telemedicine is offered as a modality of care for routine and urgent encounters to include behavioral health.

Recommended Legislation:

Legislation may be required to maximize the opportunities afforded by telemedicine. Any legislative recommendations of the Secretary will be provided to Congress through the Department's regular legislative and budgeting process.

A PLAN TO INCULCATE BEHAVIORAL HEALTH TREATMENT AS A FORM OF OVERALL SERVICE MEMBER READINESS IN THE SAME CAPACITY AS AN ANNUAL HEALTH ASSESSMENT

The plan to inculcate BH treatment as a core tenet of ADSM readiness begins with changing military culture and destigmatizing seeking BH care; an effort underway for many years. Department of Defense Instruction 6490.06, "Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members," April 21, 2009, sets clear expectations on supporting help-seeking behavior. It states, "It is DoD Policy to: a. Promote a culture that encourages delivery and receipt of counseling. b. Eliminate barriers to and the negative stigma associated with seeking counseling support... e. View counseling support as a force multiplier enhancing military and family readiness." Other changes to policy supporting help-seeking behavior addressed specific ADSM duty related concerns with seeking BH care. For instance, addressing a common concern regarding loss of a security clearance, DoD policy was updated to forbid the use of a history of counseling as a sole factor jeopardizing security clearance eligibility determinations.

Efforts to address stigma continue today. These efforts include:

- Several senior military leaders have offered public testimony of their own mental health treatment, such as U.S Africa Command's General (retired) Carter Ham; Senior Enlisted Advisor to the Chairman of the Joint Chiefs of Staff Ramon Colon-Lopez; and U.S. Central Command's Command Sergeant Major Christopher Greca. This top down messaging will have a positive impact on decreasing stigma through changing the culture (i.e., leadership expectations, dispelling the myth of career impact).
- The Military Departments have identified a need to move a portion of BH care into units via an effort to decrease stigma, increase early identification on BH issues, improve ADSM and family member resiliency, and provide real time consultation for unit leaders. These embedded BH providers conduct personnel assessment and selection, as well as focus on unit and individual ADSM mental, physical, and cognitive performance enhancement.
- The Army has recently implemented a new brigade and battalion commander assessment and selection process, which includes interviews with BH professionals. Early feedback has been positive. BH professionals now play a significant role in the assessment and selection of ADSMs for special duty assignments, then help coach trainees to improve performance and resiliency.

- The Navy has moved one third of their AD BH professionals to embedded positions to get them closer to line personnel. Preservation of Force and Family funded providers treat unit ADSMs and family members with concerns early, and seeking BH assistance is overwhelmingly supported.
- The Air Force is deploying Operation True North, an effort to embed over 500 BH professionals in line units, and is executing a multi-year plan to target certain high risk units with Operational Support Teams comprised of BH and other allied health professionals.
- DoD continues to partner with several non-MTF BH services to include Chaplains, Military Family Life Counselors, Military OneSource, and other programs.

It is important to note that in addition to the many Military Department efforts currently underway to decrease stigma, there is a national movement toward less stigma surrounding seeking BH care. The American Psychological Association’s October 2018 report “Stress in America; Generation Z” shows national cultural norms are shifting. While young adults report more BH concerns, there is less concern about stigma, and more willingness to seek BH care than earlier generations. While there is more work to be done, the Military Departments are actively addressing BH-related stigma.

A STRATEGY TO INCREASE THE NUMBER OF BEHAVIORAL HEALTH PROVIDERS FOR THE DEPARTMENT AND STANDARDIZATION OF THE CREDENTIALING REQUIREMENTS ACROSS THE SERVICES

Efforts to Increase the Number of BH Providers for the Department

This section builds upon the findings in the Report to Congress on section 702 of the NDAA for FY 2020 (Public Law 116-92), Strategy to Recruit and Retain Mental Health Providers, published November 2020. (<https://www.health.mil/Reference-Center/Congressional-Testimonies/2020/11/04/Strategy-to-Recruit-and-Retain-Mental-Health-Providers>)

BH services are provided by a mix of AD, civilian, and contracted providers. The provider staff is, in turn, comprised primarily of psychiatrists, psychologists, social workers, with licensed mental health counselors (LMHC), psychiatric physician assistants (PPA), and PMHNP making a small percentage of the workforce. The Department is beginning to expand the utilization of LMHCs and PPAs as one way to increase the number of BH providers, but these efforts are in their infancy. As a result of this complex network of different types of providers, educational requirements, pay expectations, and national distribution of providers, strategies to increase the number are equally complex. Challenges facing recruitment for the DCN include: AD authorizations, dedicated funding and manpower for recruitment, salary caps, lengthy hiring processes, remote locations, and national BH provider shortages. Opportunities currently available to the DoD include increasing the quality and size of training pipelines and building on TBH capabilities.

A 2018 U.S Department of Health and Human Services (HHS) report on *State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030*, predicts a growing nationwide shortage of psychiatrists and mental health counselors, and a continued shortage of psychologists in Midwestern and southern states. This prediction foreshadows increasing difficulty recruiting and retaining BH professionals, as members of these professions have more options and bargaining power. Further investigation into the cause of national shortages is necessary in order to determine effective national strategies for mitigation.

a. AD End Strength: As evident from Table 1, the Air Force and Navy rely heavily on AD providers to provide BH services. With the exception of psychiatrists, AD provider end strength is subject to force structure limitations determined by the Military Departments in order to meet Defense Officer Personnel Management Act (DOPMA) requirements. Increases in AD BH providers drive offsets in other medical officer career fields thereby limiting the flexibility the Military Departments have to increase AD authorizations. Where possible, DHA will support the Military Departments' ongoing efforts to balance increases in BH provider career fields against offsets in other career fields to conform with DOPMA requirements.

b. AD Compensation: Increased pay, often in exchange for a service commitment, is a primary way the Military Departments have attempted to increase recruitment and retention of qualified AD BH professionals. Until recently, compensation for military health professions officers was limited to a rate that was generally less than the median compensation for military physicians, including behavioral health professionals (GAO-20-165). With the William M. (Mac) Thornberry NDAA for FY 2021, however, Congress authorized significant increases for special and incentive pay. As the Military Departments must now plan and program funding into the two-year budget cycle and have discretion in execution, it is premature to determine the impact these increases will have in addressing recruitment and retention of AD BH officers. DHA will partner with the Military Departments to monitor the results of the increased special and incentive pay and adjust the strategy to recruit and retain BH providers as indicated.

c. Education and Training Programs: Graduate medical education and graduate professional education programs are the primary pipeline for recruitment of AD BH professionals. Continuing to offer state of the art training programs focused on developing highly valued skills while increasing the capacity of the pipeline is expected to yield increases in overall BH professional manning. DHA will partner with the Military Departments to explore the feasibility of increasing scholarships and manpower authorizations for civilian training in exchange for military service. Expanding the capacity of the Uniformed Services University of the Health Sciences is likewise expected to have positive impacts on manning.

d. Civilian Personnel/Human Resources Policies and Practices: Hiring and compensation are two areas of particular concern to civilian BH manpower:

1. Hiring Timelines: Over the past several years, civilian personnel systems have made modest improvements to the civilian recruiting and hiring processes, however, timelines remain long. A recent query of hiring actions at Walter Reed National Military Medical Center indicated the average time to hire civilians for various BH-related specialties was:

Psychiatrists = 546 days
Psychologists = 304 days
Social Workers = 224 days
Average Time to Hire for internal promotions = 90 days

These timelines often end up working against the system itself as 50 percent (3/6) of external hiring actions for psychiatrists in this survey resulted in the candidate declining the position, leading the system to restart the hiring action at the recruitment stage.

2. Compensation: Current civilian personnel policies and laws allow some flexibility to offer various types of bonuses and special pays to civilian providers. The Military Departments are granted authority to adjust these bonuses and special pays based on staffing levels and budget allocations. However, as with AD providers, compensation for civilians is limited by law, making recruitment and retention difficult, especially in underserved areas where civilian providers command higher salaries. Furthermore, other Government agencies such as the VA have more legal flexibility in civilian pay structure and plans, making competition for BH professionals uneven across Government health care providers. DHA will encourage the Military Departments to focus particular attention on ensuring civilian BH provider pay is as commensurate and attractive as possible within current legal limits in order to minimize the impact of lower compensation on retention and recruitment.

While contracts offer more flexibility in compensation, contracting companies are often unable or unwilling to provide sufficiently attractive packages to attract qualified applicants, especially for positions in remote or austere locations. Additionally, the uncertainty of contracted positions makes them unpalatable for many BH professionals. As DHA assumes authority, direction, and control of all MTF contracts, there will be a period of review and consolidation of existing personal services contracts to gain efficiencies across the Department. In awarding contracts, DHA will pay particular attention to compensation concerns and incentives that prospective contracting companies intend to employ to recruit and retain the most qualified BH providers.

e. Austere Locations: Recruiting and retaining personnel at installations in remote, austere, and unpopular locations is especially challenging and demonstrates the impact of non-pay related factors. The Military Departments continue to focus considerable time, attention, and money into improving quality of life services and activities for military and civilian employees, although difficulties in hiring remain. Utilizing a higher proportion of AD providers provides some mitigation but also increases the risk that they will separate from military service to avoid a subsequent remote assignment. Increasing military and civilian pay is expected to have a positive impact on recruitment and retention, although it would need to be able to exceed civilian compensation packages in more desirable locations by such a margin as to outweigh quality of life and other non-pay factors. As noted above, DHA will support the Military Departments' ongoing efforts to balance AD manpower increases in BH provider career fields against offsets in other career fields to conform to DOPMA requirements, encourage the Military Departments to use all tools available to make civilian compensation as attractive as possible, and support ongoing quality of life improvements in austere locations.

f. Tele-Behavioral Health: The Department of HHS report noted above further demonstrates an imbalance in supply and demand of BH professionals in many states. For example, the Northeast United States has an overage in nearly every BH-related field while the Southeast United States has shortages. Expanding the use of TBH capabilities will assist by leveraging overages in some locations to fill gaps in others. The DoD will continue to explore and build upon TBH capabilities to augment installation-based staff.

In summary, the DoD recognizes that an increase in BH providers is required to meet current and future demand and that opportunities within current limitations that will provide moderate increases in BH provider manning. The DoD is committed to retaining well-performing employees, and will continue to utilize various tools and programs to encourage retention.

Standardized Credentialing Requirements Across the Military Departments

The credentialing process for behavioral health providers is outlined in DHA-Procedural Manual 6025.13, "Clinical Quality Management in the Military Health System, Volume 4: Credentialing and Privileging," August 29, 2019. This document covers the requirements for licensure, credentials, and provider competency assessment, and also describes the Privileging Authority and privileging process in all MTFs.

DHA is currently conducting a comprehensive review of BH credentialing to include the master privileging lists and related policies. This standardization effort will ensure consistency with all requirements across the Military Departments, to include embedded providers in line units, as well as TRICARE. There is also consensus among the Military Departments and DHA to expand the BH provider types to include psychiatric physician assistants and licensed professional counselors. This credentialing standardization effort will ensure all providers are capable of performing key tasks and practicing at the top of their license, reduce variance between provider types with overlapping privileges, and increase efficiency through the credentialing and privileging process.

SUMMARY

The MHS recognizes the importance of high quality, readily accessible BH care for all military beneficiaries' readiness and quality of life. DHA, with the Military Departments, conducted a thorough review of BH manning which concluded there is a significant gap between BH providers authorized and the BH providers needed to deliver BH care to all beneficiaries. Despite this understaffing, DHA continues to focus on a comprehensive approach to address the shortage of BH providers and innovate new ways to deliver care effectively and efficiently through various means such as TBH. DoD remains committed to providing all beneficiaries with premier BH care that is free of stigma, barriers, and available to all who need to access care.